PRINTED: 05/17/2011 FORM APPROVED

CENTERS FOR MEDICARE & MEDIC	CAID SERVICES		OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00	COMPLETED
	155414	B. WING	04/28/2011

		STREET ADDRESS CITY STATE ZIP CODE					
NAME OF PROVIDER OR SUPPLIER							
NURSING AND REHABILITATION CENTER							
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE				
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	F0000						
· ·							
IN00089028.							
Complaint IN00089028- Substantiated							
_							
_							
Survey dates: April 25, 26, 27 and 28,							
2011							
1							
AIM number: 100288370							
Survey team:							
-							
Marla Potts, RN							
Census bed type:							
SNF/NF: 32							
Total: 32							
Census payor type:							
Medicare: 7							
Medicaid: 18							
Other: 7							
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  This visit was for a Recertification and State Licensure survey. This visit included the Investigation of Complaint IN00089028.  Complaint IN00089028- Substantiated. No deficiencies related to the allegations are cited.  Survey dates: April 25, 26, 27 and 28, 2011  Facility number: 000333 Provider number: 155414 AIM number: 100288370  Survey team: Melinda Lewis, RN TC Sharon Whiteman, RN Marla Potts, RN  Census bed type: SNF/NF: 32 Total: 32  Census payor type: Medicare: 7 Medicaid: 18	PROVIDER OR SUPPLIER  NURSING AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  This visit was for a Recertification and State Licensure survey. This visit included the Investigation of Complaint IN00089028.  Complaint IN00089028- Substantiated. No deficiencies related to the allegations are cited.  Survey dates: April 25, 26, 27 and 28, 2011  Facility number: 000333 Provider number: 155414 AIM number: 100288370  Survey team: Melinda Lewis, RN TC Sharon Whiteman, RN Marla Potts, RN  Census bed type: SNF/NF: 32 Total: 32  Census payor type: Medicare: 7 Medicaid: 18	PROVIDER OR SUPPLIER  NURSING AND REHABILITATION CENTER  SUMMARY STATEMENT OF DETICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  This visit was for a Recertification and State Licensure survey. This visit included the Investigation of Complaint IN00089028.  Complaint IN00089028- Substantiated. No deficiencies related to the allegations are cited.  Survey dates: April 25, 26, 27 and 28, 2011  Facility number: 000333  Provider number: 155414  AIM number: 100288370  Survey team: Melinda Lewis, RN TC Sharon Whiteman, RN Marla Potts, RN  Census bed type: SNF/NF: 32  Total: 32  Census payor type: Medicare: 7 Medicaid: 18				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XTC111

Facility ID:

000333

TITLE

If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X			X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED		
		155414	B. WING			04/28/20	011
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
LINTON	NURSING AND REI	HABILITATION CENTER		1501 A S LINTON,	, IN47441		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		EFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
1110	Sample: 10	ESC ISENTI TINO IN ORGANITON		ing			DATE
F0221	These deficiencies findings cited in 16.2.  Quality review comby Bev Faulkner,	es also reflect state accordance with 410 IAC completed on May 3, 2011 b, RN the right to be free from any					
SS=D	physical restraints discipline or conve	imposed for purposes of enience, and not required to medical symptoms.	F022	21	Preparation and/or execution	of	05/28/2011
	Based on	observation,			this plan does not constitute admission or agreement by the		
	interview	and record			provider of the truth of the fac alleged or conclusions set for	rth	
	review, th	e facility failed			on the statement of deficienc This plan of correction is		
	to ensure	a restraint was			prepared and/or executed so because required. F 221		
	used for th	ne least amount			Restraints (a) What corrective action(s) will be accomplished	d for	
	of time po	ssible, in that			those residents found to have been affected by the		
	the facility	y did not have	in place. the medical symptoms resulting in the applied restraint.		ify		
	a reductio	n plan in place,					
	for 1 of 1	residents			Occupational Therapy evalua was completed to provide recommendations and follow		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
111,212,11	or condition.	155414	A. BUI B. WIN	LDING		04/28/2	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF	PROVIDER OR SUPPLIEF	{		1501 A	ST		
LINTON	NURSING AND RE	HABILITATION CENTER		LINTON	I, IN47441		
(X4) ID		STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECT			(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL  LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
					through with least restrictive		Biii
	reviewed with restraints				measure and staff education.		
	in a samp	le of 10.			Education completed with the and nursing for documentation		
	_				release of restraint and resid	ent's	
					participation in transfer and walking programs. Educatio	n	
	Resident 7	#19			completed with all staff on ne	eed	
					for resident to be free of rest during meals and supervised		
		. 1 1			activities. (b) How you will	•	
	Findings include				identify other residents hav	-	
					potential to be affected by t same practice and what	he	
					corrective action will be take	en:	
	On the ini	itial tour, on			Facility QI/QM will be ran to		
	4/25/11 at	t 9:15 A.M., the			identify all residents with restraints in last 6 months. T	he	
		rvices Director			interdisciplinary team will rev	riew	
	Social Sci	IVICES DIFECTOR			residents and determine interventions selected are the	e	
	indicated	Resident #19			best for residents maintaining	-	
	was confi	ised and used a			highest level of functional an least restrictive measure and		
					their plan of care reflects all		
	soft belt r	estraint.			above (c) What measures	will	
					be put into place or what systematic changes you wi		
	0 4/05/1	1 . 10 15			make to ensure that the		
	On 4/25/1	1 at 12:15			practice does not recur: 1. Facility staff will be re-educa	tod	
	P.M., Res	ident # 19 was			on identification of the medic		
	ĺ				symptoms that are warranted		
		to be sitting in			prior to restraint determination and selection. 2. Staff will be		
	the dining	groom.			in-serviced on the document		
	Resident 7	# 19 was			of alternative interventions pure restraint application, initiation		
					pre-restraining assessment,		
	observed	to be in a			physician orders identifying t of restraint, medical diagnosi		
					5. Toolianit, modical diagnosi	,	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		155414	B. WIN			04/28/2	011
NAME OF	PROVIDER OR SUPPLIEF	2		1	DDRESS, CITY, STATE, ZIP CODE		
LINTON	NURSING AND RE	HABILITATION CENTER		1501 A	ST I, IN47441		
(X4) ID	-	STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	_	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΙΕ	DATE
	wheelchair with a soft belt restraint.				time frames for wearing the frequency of checking and		
					removal. The plan of care will be		
					updated as above with the initiation of the restraint and		
					during the restraint elimination		
	On 4/25/1	1 at 1:30 P.M.,			assessment. 3. Nursing staf be in-serviced on necessary	f will	
		,			documentation of release of		
	Resident 7	+ 19 was			restraint at meals and other supervised activities.4. Residual	lents	
	observed	to be			with restraints will be discuss		
	nronelling	self about the			regularly scheduled IPOC meetings, and at the quarterl	lv	
	propelling self about the				annual and/or significant cha		
	facility. R	esident # 19			MDS. 5. Any resident with a restraint identified to have a		
	was obser	ved to be in a			change of condition will be		
	wheelchai	ir with a soft			reported in the 24 hour report discussed in morning meeting		
		_			Interdisciplinary team member	ers	
	belt restra	int.			will review identified resident care plan meetings. (d) Hov		
					corrective action(s) will be		
	0 . 4/2 (/1	1 -4 O.4O A M			monitored to ensure the		
	On 4/26/1	1 at 9:40 A.M.,			practice will not recur, i.e., what quality assurance		
	Resident 7	# 19 was			program will be put into pla		
	observed	to be observed			Responsible party for this Pla Correction includes the DNS.		
					who will do a facility walk-thr	u to	
	to be sittii	ng in her room.			visually review the residents identify any use of articles the		
	Resident 7	# 19 was			might be viewed as a restrain		
	observed to be in a				and correlate this with the resident's plan of care. Then	this	
					will be monitored by the Reg		
	wheelchai	ir with a soft			Rehab Director when she completes quarterly system		
	belt restra	int			reviews which includes restra		
		,111¢.			Any discrepancies identified be immediately addressed as		
	<u> </u>				be ininieulately addressed al	iu	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155414		(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE COMP: 04/28/2	LETED
	PROVIDER OR SUPPLIER	HABILITATION CENTER	STREET A 1501 A	ADDRESS, CITY, STATE, ZIP C ST N, IN47441	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
TAG	On 4/26/1 Resident # observed f propelling facility. R was observed wheelchair belt restra  The clinic Resident # reviewed 11:10 A.N indicated had diagn included b limited to arthritis. T	1 at 2:00 P.M., # 19 was to be g self about the esident # 19 wed to be in a fir with a soft int.  eal record for # 19 was on 4/25/11 at M. The record Resident # 19 oses that out were not dementia and	TAG	reported to the NHA. these findings will be the next Risk Manag Meeting to assure co maintained. (e) Dat compliance: 5-28-1	e presented to lement/QA ompliance is le of	DATE
			1	I		I

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155414		A. BUII	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			SURVEY LETED 2011
	PROVIDER OR SUPPLIER	HABILITATION CENTER	р. үүлү	1501 A	DDRESS, CITY, STATE, ZIP CODE ST I, IN47441		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E	(X5) COMPLETION DATE
	assessmer	nt, dated					
	3/19/11, ii	ndicated					
	Resident #	# 19 had severe					
	cognitive	impairment,					
	and requir	ed extensive					
	assistance	of one with					
	bed mobil	ity, transfers,					
	ambulation and toilet						
	use. Resid	dent # 19					
	utilized a trunk restraint						
	daily.						
	requires p restraint to from harm type: 3/16	ndicated a of "Resident					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	СО	ATE SURVEY MPLETED	
		155414	B. WIN		DDDEGG GITY CTATE ZID GO		28/2011 
NAME OF I	PROVIDER OR SUPPLIER			1501 A	DDRESS, CITY, STATE, ZIP CO ST	DE	
		HABILITATION CENTER		<u> </u>	l, IN47441		
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	target beh	aviors:					
	agitation,	obsession with					
	bodily fur	nctions,					
	constant a	ttempts to					
	toilet self.	Medical					
	symptoms	s: dementia,					
	poor safet						
	Less restrictive or						
	alternative	e non restraint					
	approache	es that have					
	proven to	be					
	INEFFEC	CTIVE:					
	self-releas	se seat belt, lap					
	buddy." T	he approaches					
	were "Mo	nitor for and					
	report to t	he physician					
		ring restraint					
	related iss						
	Developm	nent of or					
	increase in	n					

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE S COMPLE	
		155414	A. BUIL B. WING		04/28/2011		)11
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
LINTON	NURSING AND REI	HABILITATION CENTER	-		I, IN47441		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		mood problem,					
	decreased mobility,						
	developm	ent of					
	contractur	es,					
	developm	ent of skin					
	problems,	development					
	of or incre						
	incontinence, increased						
	risk for fa	lls/injuries.					
	Educate						
	resident/re	esponsible					
	party of th	ne following					
	risks asso	ciated with use					
	of above of	device:					
	behavior/1	mood					
	problems,	contractures,					
	decreased	mobility.					
	incontiner	nce, ADL					
	activities	of daily					
	_	cline, skin					

NAME OF PROVIDER OR SUPPLIER  LINTON NURSING AND REHABILITATION CENTER  (X4) ID PREFIX TAG  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 1501 A ST LINTON, IN47441  LINTON, IN47441  ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 1501 A ST LINTON, IN47441  LINTON, IN47441  COMPLETED TO THE APPROPRIATE DEFICIENCY  COMPLETED TO THE APPROPRIATE DEFICIENCY)  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 1501 A ST LINTON, IN47441  CAN DEPOSITE OF THE APPROPRIATE DEFICIENCY  COMPLETED TO THE APPROPRIATE DEFICIENCY  COMPLETED TO THE APPROPRIATE DEFICIENCY  DATE  TO THE APPROPRIATE DEFICIENCY  COMPLETED TO THE APPROPRIATE DEFICIENCY  AND THE APPROPRIATE DEFICIENCY  COMPLETED TO THE APPROPRIATE DEFIC	
PREFIX TAG  (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATI  COMPLE TAG  Screen for	
Screen for	
annronriateness of the	
appropriateless of the	
device PRN [as needed]	
PT [physical therapy],	
OT [occupational	
therapy]. Restraint per	
physicians order: Type:	
Lap belt. Parameters for	
use: when up in w/c D/T	
[due to] safety issues.	
Frequency of checking	
and removing restraint:	
check Q [every] 30 min	
and release Q 2 hrs. with	
activity. Invite,	
encourage, remind,	
escort to activity	
programs consistent with	
residents interests.	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A (X2	(X2) MULTIPLE CONSTRUCTION				(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155414		BUILDING	00		04/28/2		
		-	В. `	WING STREET A	DDRESS, CITY, STA	ATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIER			1501 A S		, 2 0000			
LINTON	NURSING AND RE	HABILITATION CENTER		LINTON	, IN47441				
(X4) ID		TATEMENT OF DEFICIENCIES		ID		PLAN OF CORRECTION		(X5)	
PREFIX TAG	*	CY MUST BE PERCEDED BY FU LSC IDENTIFYING INFORMATI		PREFIX TAG	CROSS-REFERENCI	/E ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY)	≣	COMPLETION DATE	
	Provide sa	nfe							
	environme	ent, call light							
	and personal items								
	within rea	ch, bed in low	7						
	position. I	•							
	restraint elimination								
	assessment quarterly and								
	PRN. Obtain physical								
	restraint in	nformed							
	consent fr	om resident							
	responsibl	le party."							
	The Nurse	es Notes, dated	1						
		ŕ	л 						
	3/13/11 no	,							
	indicated	"Self							
	releasing a	alarmed belt							
	which resi	ident will							
	unbuckle	et [and]							
	rebuckle.	Poor safety							
	awareness	5"							
FORM CMS-2	567(02-99) Previous Versio	ns Obsolete Event	ID: XTC1		D: 000333	If continuation she	eet Pac	l ge 10 of 27	

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPL		
		155414	A. BUII B. WIN			04/28/2	04/28/2011	
NAME OF P	PROVIDER OR SUPPLIER			1501 A	ADDRESS, CITY, STATE, ZIP CODE ST			
LINTON	NURSING AND RE	HABILITATION CENTER			N, IN47441			
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE.	DATE	
	The Nurses Notes, dated							
	3/14/11 at	9:00 A.M.,						
	indicated	"Late entry for						
	3-13-11 at	10:00 P.M.						
	Res [resident] had lap							
	buddy placed on w/c, res							
	took lap b	uddy off x						
	[times] 2. 15 min checks							
	cont [cont	inues]."						
	The Nurse	es Notes, dated						
	3/15/11 at	2:00 P.M.,						
	indicated	"This shift,						
	dayshift, r	es found in						
	room once	e and in BR						
	[bathroom	once with lap						
	buddy off.	. 15 min						
	_	nt. Explained						
		ortance of						
	p							

000333

	OF CORRECTION	IDENTIFICATION NUMBER:			NSTRUCTION 00	COMPI	
		155414	A. BUI B. WIN	LDING IG		04/28/2	2011
NAME OF I	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
LINTON	NURSING AND RE	HABILITATION CENTER			I, IN47441		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI	1	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	IATE	DATE
	leaving la	p buddy on					
	D/T [due	to] safety."					
	The Nurse	es Notes, dated					
	3/15/11 at	6:00 P.M.,					
	indicated	"Resident					
	found x 2	removing lap					
	buddy in 1	restroom.					
	Found x 1	by OT					
	removing	lap buddy also.					
	While this	s nurse was					
	serving di	nner trays I					
	noted lap	buddy not on					
	and she st	ated she had					
	taken it of	ff and left it on					
	her bed. L	ap buddy					
	replaced."	•					
	1						
	The Nurse	es Notes, dated					
		: 12:15 P.M.,					
	Di I Oi I I W						

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155414	(X2) MULTIPLE ( A. BUILDING B. WING	OO OO	COM	TE SURVEY MPLETED 3/2011
	PROVIDER OR SUPPLIER	HABILITATION CENTER	STREE*	T ADDRESS, CITY, STATE, ZIP A ST DN, IN47441	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	indicated	"Res attempted				
	to toilet se	elf staff noted				
	et question	ned if res				
	needed he	lp res stated no				
	et propelle	ed w/c down				
	hallway. S	Shortly after res				
	noted in different					
	bathroom with lap buddy					
	off. Resid	ent toileted."				
	3/16/11 at indicated attempted x 5. Is toil and prn. T	to transfer self leted q 2 hours Therapy aware. It for order for int as all live been				

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155414	(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	CO	ATE SURVEY MPLETED 8/2011
	PROVIDER OR SUPPLIER	HABILITATION CENTER	p. wiiv	STREET A	DDRESS, CITY, STATE, ZIP COI ST I, IN47441	DE	
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		response."					
		es Notes, dated					
		5:00 P.M., "Contacted Dr					
		d received					
	`	ap restraint					
	while up in w/c d/t [due						
	to] other r	non restraint					
	approache	es not being					
	effective	."					
	A physicia	an order, dated					
	3/16/11, in	ndicated "May					
	use lap res	straint."					
	A Pre-rest	<b>C</b>					
	Assessme						
	3/16/11, ii						
	"Interdis	scipiinary					

	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE S COMPL	
	155414		G		04/28/20	011
ROVIDER OR SUPPLIER						
NURSING AND RE	HABILITATION CENTER		1			
			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	_	(X5) COMPLETION
REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
Team Eva	luation- Date					
3/16/11.						
Recomme	endations: lap					
restraint w	when up in w/c					
per OTA	Alternatives to					
restraints	(include length					
of time to	be tried) have					
tried lap b	ouddy since					
2/24/11. R	Res removed					
continuou	sly, not					
safeAlrea	ady on OT					
caseload.	PT screened on					
2-23-11 aı	nd					
recommer	nded lap buddy					
as a trial."						
A Physica	1 Restraint					
•						
	,					
	,					
10	nave som lap					
]	ROVIDER OR SUPPLIER SUMMARY'S (EACH DEFICIEN REGULATORY OR TEAM EVA 3/16/11.  Recommer restraint was per OT A restraints of time to tried lap by 2/24/11. Recontinuous afe Alrest caseload. 2-23-11 arrecommer as a trial."  A Physica Eliminatic dated 3/19 are commer as a trial."	ROVIDER OR SUPPLIER  NURSING AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Team Evaluation- Date	ROVIDER OR SUPPLIER NURSING AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Team Evaluation- Date 3/16/11.  Recommendations: lap restraint when up in w/c per OTAlternatives to restraints (include length of time to be tried) have tried lap buddy since 2/24/11. Res removed continuously, not safeAlready on OT caseload. PT screened on 2-23-11 and recommended lap buddy as a trial."  A Physical Restraint Elimination Assessment, dated 3/19/11, indicated	ROVIDER OR SUPPLIER  ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Team Evaluation- Date  3/16/11.  Recommendations: lap restraint when up in w/c per OTAlternatives to restraints (include length of time to be tried) have tried lap buddy since  2/24/11. Res removed continuously, not safeAlready on OT caseload. PT screened on 2-23-11 and recommended lap buddy as a trial."  A Physical Restraint Elimination Assessment, dated 3/19/11, indicated	ROYIDER OR SUPPLIER NURSING AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MUST BE PERCEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Team Evaluation- Date  3/16/11.  Recommendations: lap restraint when up in w/c per OTAlternatives to restraints (include length of time to be tried) have tried lap buddy since  2/24/11. Res removed continuously, not safeAlready on OT caseload. PT screened on 2-23-11 and recommended lap buddy as a trial."  A Physical Restraint  Elimination Assessment, dated 3/19/11, indicated	DESCRIPTION NUMBER: 155414  ROVIDER OR SUPPLIER  ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCES  SUMMARY STATEMENT OF DEFICIENCES  SUMMARY STATEMENT OF DEFICIENCES  SUMMARY STATEMENT OF DEFICIENCES  REGULATORY OR LSC IDENTIFYING INFORMATION)  Team Evaluation- Date  3/16/11.  Recommendations: lap restraint when up in w/c per OTAlternatives to restraints (include length of time to be tried) have tried lap buddy since  2/24/11. Res removed continuously, not safeAlready on OT caseload. PT screened on 2-23-11 and recommended lap buddy as a trial."  A Physical Restraint Elimination Assessment, dated 3/19/11, indicated

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155414	(X2) MUL A. BUILD B. WING		NSTRUCTION  00	(X3) DATE S COMPL 04/28/2	ETED
	PROVIDER OR SUPPLIER	HABILITATION CENTER		1501 A S	ODDRESS, CITY, STATE, ZIP CODE ST I, IN47441	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	belt D/T [	due to] poor					
	safety awa	areness D/T					
	dementia.	Gets up					
	unassisted	l frequently to					
	toilet self.	High fall					
	risk."						
	In an interview with the						
	Director of	of Nursing, on					
	4/26/11 at	1:30 P.M., she					
	indicated	Resident # 19					
	had fallen	and the soft					
	lap belt w	as to keep her					
	from furth	ner falls.					
	In an inter	rview with the					
	Rehab Dia	rector, on					
	4/27/11 at	11:00 A.M.,					
	she indica	ited she was					
	going to p	provide an					

	OF CORRECTION	IDENTIFICATION NUMBER: 155414	(X2) MULTIPLE CC  A. BUILDING  B. WING	00	COMPI 04/28/2	LETED
	PROVIDER OR SUPPLIER	HABILITATION CENTER	STREET A 1501 A	ADDRESS, CITY, STATE, ZIP COI ST N, IN47441	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	inservice	to the staff on				
	the need to	o remove the				
	soft belt re	estraint during				
	supervisio	on. She				
	indicated	the staff would				
	be educate	ed to release				
	the restrai	nt during				
	activities	and meal times.				
	3.1-3(w)					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155414	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 04/28/2011
	ROVIDER OR SUPPLIER		STREET A 1501 A		
		HABILITATION CENTER		N, IN47441	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155414	B. WING			04/28/2	011
	ROVIDER OR SUPPLIER	HABILITATION CENTER	1	STREET A. 1501 A S	DDRESS, CITY, STATE, ZIP CODE ST I, IN47441		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	IX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE
F0328 SS=D	The facility must eproper treatment a special services: Injections; Parenteral and enterior Colostomy, uretered Tracheostomy care; Tracheostomy care; Foot care; and Prostheses.  Based on obserview, and infailed to follow for oxygen to be review, and infailed to follow for oxygen to be resident's review sample of 10.  Findings Inclusion On 04/25/11 at #12 was observed to oxygen tank when the man was observed to oxygen tank when the man of the resident oxygen tank when the man ox	rvation, record terview, the facility v physician's order be supplied to 1 of 2 ewed for oxygen in a (Resident #12)  de:  t 10:10 a.m., Resident ved seated in her the hall with oxygen nostrils. The resident to be hooked up to an vhich was not turned ent did not appear to	F0	328	Preparation and/or execution of plan does not constitute admissi agreement by the provider of the truth of the facts alleged or conclusions set forth on the state of deficiencies. This plan of correction is prepared and/or executed solely because require.  F 328  A) What corrective action(s) with accomplished for those resident found to have been affected by a practice:  RN#1 had teachable moment presented by the Director of Nu Services with a focus on "Guide for Administrating Medications which included standards for oxuse and orders.  B) How you will identify other residents having potential to be affected by the same practice a what corrective action will be taken:  Audit was conducted of currents	on or e ement  d.  Il be s the elines  rygen  e and	05/28/2011
	up the hall and	I told the resident,			residents receiving oxygen. No negative outcomes were identifi		

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155414	B. WIN			04/28/2011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	
LINTON	NURSING AND REI	HABILITATION CENTER		1501 A LINTON	S) N, IN47441	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	<u> </u>	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	"You need a ta	nk."			those residents identified.	
					C) What measures will be put	into
	On 04/25/11 at	t 11:55 a.m., and			place or what systematic chan	-
	12:55 p.m., R	esident #12 was			you will make to ensure that t	he
	_	ed in her room in a			practice does not recur: Licensed nurses were re-educat	ad any
					Standard and Guidelines for Dr	
		The resident was			Administration - with specific f	-
	observed to have oxygen tubing in her nostrils and the tubing was				on oxygen use and orders.	
	attached to a c	ondenser, which was			D) How the corrective action(s	·
	set on 2 liters.	,			will be monitored to ensure th practice will not recur, i.e., wh	
	Set on 2 mers.		quality assurance program will be			
	0.04/06/11	10.55		put into place:		
		t 9:30 a.m. and 9:55				
	a.m., Resident	#12 was observed			DNS/Designee will do a weekly	I
	seated in her ro	oom in a recliner with			random review of oxygen for the next four weeks then twice a m	I
	oxvgen tubing	in her nostrils. The			X 2 months to include all shifts	
	oxygen was se				weekends to identify any oxyge	I
	oxygen was se	t at 2 mers.			being administered per facility	
					standards. Any issues identified	l will
					be immediately corrected and	10
	Review of Res	sident #12's clinical			reported to the NHA. The above audits will be reviewed at the n	
	record on 04/2	5/11 at 11:00 a.m.,			Risk Management/QA committ	
	indicated the f	· ·			meeting to determine if complia	l l
		· · · · · · · · · · · · · · · · · · ·			has been met and recommended	
	Desident #121	and diagnoses which			monitoring will be quarterly by RDCO when she completes her	I
		nad diagnoses which			system reviews which includes	I
	· ·	vere not limited to,			physician orders (including ord	
	Organic Brain	Syndrome,			for oxygen).	
	Alzheimer Dis	ease, congestive				.
	heart failure. P	neumonia, Renal			E) Date of compliance: 5-28-1	1
	Insufficiency,					
	· · · · · · · · · · · · · · · · · · ·	· ·				
	Saturation, CIII	onic renal failure.				

000333

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		NSTRUCTION 00	(X3) DATE SURVEY  COMPLETED
		155414	B. WIN			04/28/2011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
LINTON	NURSING AND REI	HABILITATION CENTER		1501 A	ST I, IN47441	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENC!)	DATE
	A physician's t	alanhana ardar				
		relephone order,				
	dated 04/05/11	•				
	indicated, "Co					
	` ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	n per (nasal cannula)				
	@ 2 (liters).					
	A physician's t	elephone order,				
	dated 04/14/11 at 3:00 p.m.,					
	indicated, "Send (Resident #12)					
	to (local hospi	,				
	room)"					
	100111)					
	A "Daily Skille	ed Nurses Notes,"				
	dated 04/14/11	*				
		esident #12) fainted.				
	' '	c) resident to floor				
	, i	emperature) 97.7,				
	· · · · · · · · · · · · · · · · · · ·	e) 140/96, (oxygen				
	` •	%, (heart rate) 86,				
	(respiratory rate	· ·				
		ic) 10.				
	A "Daily Skille	ed Nurse's Note,"				
	dated 04/14/11					
		vsician) notified				
	` •	unable to stand and				
	lethargic. (Phy					
	, , ,	tch for 1 (hour) if no				
		(Emergency Room)."				
	better seria to	Lineigency Koomj.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED 04/28/2011
		155414	B. WING	ADDRESS STEEL STEE	04/20/2011
NAME OF I	PROVIDER OR SUPPLIER		1501 A	ADDRESS, CITY, STATE, ZIP CODE	
LINTON		HABILITATION CENTER	l l	N, IN47441	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI	ATE COMPLETION DATE
_					
	A "Daily Skill	ed Nurse's Note,"			
	dated 04/14/11	at 3:15 p.m.,			
	indicated, "(Lo	ocal ambulance			
	company) will				
	(Emergency R	-			
	(======================================				
	A "Hospital/A	cute Care Transfer"			
	•	1/14/11, indicated			
	, and the second	was transferred to the			
		The transfer sheet			
		dent #12 fainted			
		ansferred by a CNA.			
		neet indicated the			
		gen saturation was			
	75-76 %.				
	4 D1 : 1 T1	D 31.4			
		erapy Progress Note,			
		, indicated Resident			
	#12 did not red	• •			
	therapy on this				
	_	due to labored			
	breathing, leth	argy, confusion, and			
	oxygen saturat	tion of 72-73%.			
	A "Nursing Ac	lmission			
	Assessment,"	dated 04/23/11,			
	· ·	dent #12 returned to			
	the facility fro	m the local hospital			
		<b>F</b>		1	

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILAN	or correction	155414	A. BUI		00	04/28/2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			1501 A		
LINTON	NURSING AND RE	HABILITATION CENTER		LINTON	I, IN47441	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
	on this day. T					
	_	licated Resident #12				
		3 liters of oxygen via				
	nasal cannula.					
	Clinical record	l review lacked				
		supporting an order				
		3 liters via nasal				
	cannula.					
	The DON (Dir	rector of Nursing)				
	was interviewe	ed on 04/25/11 at				
	1:10 p.m., rega	arding Resident #12's				
		since re-admission				
		tal. The DON				
	indicated she v					
	physician for o	order clarification.				
ı	1 3					
	Clinical record	d review on 04/26/11				
	at 10:00 a.m.,	indicated a				
	· ·	ephone order with				
		ten under the "Date				
	Ordered" colu	mn. The physician's				
	telephone orde					
	•	written 4/25/11 -				
	Clarification:	O2 (oxygen) @ 3				
		al cannula @ all				
	(times)."					
	, , , , , , , , , , , , , , , , , , ,					

000333

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		<u> </u>			X3) DATE SURVEY  COMPLETED	
		155414	A. BUII		00	04/28/2		
		100111	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	0 1/20/2		
NAME OF PROVIDER OR SUPPLIER				1501 A				
LINTON NURSING AND REHABILITATION CENTER					N, IN47441			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE	
1710		ESC IDENTIFICATION ON MITORITY	LIDENTIFTING INFORMATION) IAG			DATE		
F0465 SS=D	sanitary, and comfresidents, staff and Based on observations without grand during 1 of 2 k. Findings Include the kitchen on a.m., with the present the followere made:  The dish wash observed to be dust/grease but machine and o underneath the	rvation and facility failed to equipment was clean easy/dust residue. tions were made citchen observations.  de:  observation tour of 04/25/11 at 9:15 Dietary Manager lowing observations  ing machine was soiled with ildup on top of the n the piping machine.	F0	465	The facility must provide a safunctional, sanitary and comfortable environment for resident, staff and public. (A)What corrective action(s) will be accomplish for those residents found to have been affected: The duand grease build up noted or dish machine and on the pipi underneath the machine was cleaned and sanitized on 4/2. The rack containing the sanitization buckets was clea and sanitized on 4/25/11. The grease/dust noted on the back and top of the juice machine cleaned and sanitized on 4/2 (B)How will you identify otheresidents having potential to be affected and what correct action will be taken: Reside receiving breakfast meals on 4/25/11 were potentially affect though, no specific resident videntified. (C)What measure will be put into place or what systemic changes will be more to ensure this will not recurred and Nutritional Service Department has been educated to the components of F 371 videous on sanitary conditions.	ned of state of the state of th	05/28/2011	
					to the components of F 371 v	with a		

000333

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION		155414		DING	00	04/28/20		
		100111	B. WINC		DDRESS, CITY, STATE, ZIP CODE	0 1/20/2	J 11	
NAME OF PROVIDER OR SUPPLIER				1501 A S				
LINTON NURSING AND REHABILITATION CENTER			LINTON, IN47441					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION	
TAG			<u> </u>	TAG	include the items noted unde	r	DATE	
	Interview of the on 04/25/11 at	top of the juice oiled with a heavy dust buildup.  The Dietary Manager 9:20 a.m., indicated should have been			section A. Review of the QIS Kitchen Inspection Tool was reviewed and will be used monthly as part of this educational process. (D)How corrective action(s) will be monitored to ensure the practice will not recur: The Consultant Dietitian, Food Service Manager and/or desi will conduct a weekly sanitati audit for a minimum of three times per week for four week then monthly X 2 months. The audit will include items noted section A. The findings/resul these audits will be reported the Risk Management/QA committee to determine if substantial compliance has be	y the gnee on s, ne in ts of to		
					achieved and quarterly monit for oversight by the RD when complete they Quarterly revie is recommended. (E) Date Certain: 5-28-11	they		
F0514 SS=D	each resident in ac professional stand complete; accurate	naintain clinical records on accordance with accepted ards and practices that are ely documented; readily estematically organized.						
	information to identhe resident's asset and services provipreadmission screstate; and progress Based on record facility failed to expend the services of the s	must contain sufficient httify the resident; a record of hessments; the plan of care htted ded; the results of any hening conducted by the hes notes.  Hereview and interview, the hensure a resident using httility had a current order	F03	514	Preparation and/or execution this plan does not constitute admission or agreement by the provider of the truth of the fac	he	05/28/2011	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING B. WING		00	COMPLETED		
		155414				04/28/2011		
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER				1501 A				
LINTON NURSING AND REHABILITATION CENTER				LINTON, IN47441				
			_	ID I	,		(V.5)	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION		
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE		
		For 1 of 2 residents	1		alleged or conclusions set fo			
		xygen orders, in the			on the statement of deficienc			
		• •			This plan of correction is			
	sample of 10. Resident #100				prepared and/or executed so			
					because required. F 514 Clir			
	Findings include				Records (a) What corrective action(s) will be accomplishe	d for		
					those residents found to have			
	1. Resident #100	0's clinical record was			been affected by the practice			
	reviewed on 4/25	5/11 at 1:00 P.M. The			This information was taken fr			
	resident returned	from the hospital on			a closed record. Active licens			
	3/30/11 and readmission orders did not				staff having cared for resider			
	include an order for oxygen. The				#100 from 3-30-11 to 4-5-11	were		
	admission Minimum Data Set (MDS)				re-educated per teachable moment on the need for oxyg	nen		
		d 4/6/11, indicated the			orders (b) How you will	JCII		
	· ·				identify other residents having			
	resident had an used oxygen in the past 14 days both at the facility and prior to facility stay.				potential to be affected by the			
					same practice and what			
					corrective action will be tak			
					. An audit was conducted of			
	Nurses notes, da	ted 3/30 through 4/5/11,			residents receiving oxygen fo	or		
	included docume	entation at least each			accurate orders no other			
	shift, that the res	ident used oxygen at 3			residents were identified. (c) What measures will be put	into		
	liter per nasal annual. Nurses notes from 4/6/11 through 4/22/11 included at least a daily entry which indicated the resident used oxygen at 2 liters per nasal cannula.				place or what systematic	iilo		
					changes you will make to			
					ensure that the practice do	es		
					not recur: Nursing staff will			
					re-educated on obtaining ord	ers		
	Daine intention	id de Dissers of			for oxygen standards and			
	_	with the Director of			guidelines, and professional			
	_	/11 at 1:00 P.M., she			standards of practices for			
		ident had been admitted			maintaining clinical record documentation of			
	to the facility with oxygen and staff had just failed to write the order. She provided a hospital progress note, dated 3/29/11, of "oxygen decreased to nasal cannula 3 liters."				assessments/orders upon re	turn		
					(d) How the corrective			
					action(s) will be monitored	to		
					ensure the practice will not			
					recur, i.e., what quality			
					assurance program will be	put		

Facility ID:

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

<b>I</b>		(X2) MULTIPLE CO		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMPLETED			
		155414	B. WING		04/28/2011		
NAME OF P	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	KOVIDEK OK SOLI EIEK		1501 A				
LINTON	NURSING AND REI	HABILITATION CENTER	LINTON, IN47441				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
	The MDS Coord	inator provided an order		into place: DNS/Designee w	vill do		
	on 4/26/11 at 1:0	0 P.M., which indicated		a weekly random review of	lea .		
	"4/26/11 12:25 p	.m., clarification order		oxygen for the next four wee			
	_	cannula 2 to 3 liters to		then twice a month X 2 months to include all shifts and weekends to			
	maintain sat abov			identify any oxygen not being			
	3/30/11."			administered per facility			
	-			standards. Any issues identif			
	3.1-50(a)(1)			will be immediately corrected			
	5.1 50(u)(1)			reported to the NHA. The at audits will be reviewed at the			
				Risk Management/QA comm			
				meeting to determine if			
				compliance has been met ar			
				recommended that monitoring	·		
				be quarterly by the RDCO wi she completes her system	nen		
				reviews which includes phys	ician		
				orders (including orders for	iolan i		
				oxygen). (e) Date of			
				compliance: 5-28-11			